Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ROSA BELENA-BRUCE, MD
3100 TIMMONS LANE #250
HOUSTON, TX 77027

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-11-3889-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER REFUSES TO PAY FULL AMOUNT DUE FOR SERVICES RENDERED EVEN AFTER A REQUEST FOR RECONSIDERATION WAS SUBMITTED."

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: A copy of dispute was placed in carrier rep box on July 11, 2011 with no response to MFDR

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 18, 2011	99456-W5-WP and 99456-MI	$500.00	$500.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits dated June 06, 2011
   - 18 – Duplicate claim/service.
   - U-301 - This item was previously submitted and reviewed with notification of decision issued to payor. Provider (duplicate invoice)

   Explanation of benefits dated June 22, 2011
   - 18 – Duplicate claim/service.
   - U-301 - This item was previously submitted and reviewed with notification of decision issued to payor. Provider (duplicate invoice)

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement for disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The requestor originally billed the amount of $650.00 on April 08, 2011 for one unit/body area using the CPT code 99456-W5-WP. On a submission of May 27th, 2011, the billing was amended to include 3 additional body areas and the billed amount changed to $1,100.00 for same CPT code 99456-W5-WP now totaling 4 units. Also added to billing was CPT code 99456-MI for $50.00. The requestor is billing for compensable areas (spinal region) as well as compensable combined with additional non-compensable areas including face and head contusions (non-musculoskeletal areas) and shoulder contusions (upper extremity). Documentation supports that MMI was assigned. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. Per Texas Administrative Code §134.204(j)(4)(C)(i)(I), lumbar, cervical, thoracic and pelvis are part of one body area, the spine. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the MAR for an IR using Diagnosis Related Estimates (DRE) Category III method on the lumbar and Category I DRE method on the cervical is $150.00 as both are part of same area (spinal region). Documentation also supports the musculoskeletal rating of the shoulder (upper extremity) per the Range of Motion (ROM) IR method per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a) with a MAR of $300.00. The IR per AMA Guides to the Evaluation of Permanent Impairment, 4th Edition for a non musculoskeletal area of the face and head is per 28 Texas Administrative Code §134.204 (j)(4)(D)(iv) and (v) with a MAR of $150.00 each. The total Combined MAR for CPT code 99456-W5-WP is $1,100.00. As Multiple Impairments were rendered, the MAR for CPT 99456-MI is $50.00. The total MAR of all services is $1,150.00.
2. The requestor has shown to have been reimbursed $650.00 for CPT code 99456-WP-W5 and $0.00 for CPT code 99456-MI according to the requestor's Table of Disputed Services. There are no EOB(s) showing reflecting any payment, only those showing reference to duplicates. Documentation supports that a request for reconsideration was made for which an EOB has not been received. Therefore an additional $500.00 is recommended.

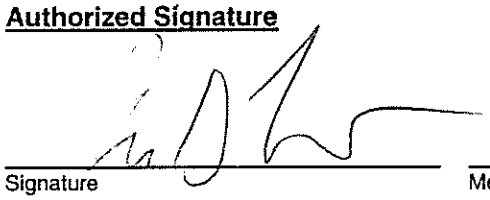
Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the additional amount ordered is $500.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the additional amount of $500.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature



Signature | Gregory Fournerat, Medical Fee Dispute Resolution Officer | January 30, 2012, Dat

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**
Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.